KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT

KATHLEEN SEBELIUS, GOVERNOR
Roderick L. Bremby, Secretary

CP No _____

HOSPITAL LTC UNIT FACILITY COMPLAINT INVESTIGATION REPORT FORM
(Please attach additional sheets as needed.)

REPORTING AGENCY

Name: _____ Phone No.: _____

Address: _____ E-mail address: _____
(Street/PO Box) (City/State) (Zip Code)

REPORTING PARTY

Name: _____
(Last) (First) (Middle initial) (Title/position)

Address: _____
(Street/PO Box) (City/State) (Zip Code)

Telephone: (___) _____ (___) _____
(Work) (Home)

INCIDENT INFORMATION

Date of Incident (on or about): _____

Information upon which this report is being made is as follows: (Please include a specific description of the incident, including the date, time, and location of the alleged incident.)

Name & Cognitive Status of Resident(s) involved:

If injured, please describe:

Corrective Actions Taken by the Facility:

Report made to law enforcement? **9** Yes **9** No Police Care # _____	Name and address of law enforcement contact

Attachments:

9 Facility Investigative Report & supportive documentation. Please include MDS, Care Plan, nursing notes pertinent to the incident as appropriate.

9 Nurse Aide Registry Verification if the alleged Perpetrator is a CNA &/or CMA

9 List of witnesses and **Notarized** Witness statements from those individuals regarding abue, neglect or exploitation by a facility staff member.

9 Completed Alleged Perpetrator Information Form (if applicable)

Attestation Statement: I certify that all the information given is true and correct.

Signature Printed Name Title Date

Please return completed form to:
Mary Kabriel, RN, Regional Manager, KDHE, BCCHF, 1000 SW Jackson, Suite 200, Topeka, KS 66612-1365

State Use Only: Review of information has been completed. **Onsite survey: Yes** 9 **No** 9

Signature **Date**

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY OR AGENCY

Agency:

City:

ALLEGED PERPETRATOR INFORMATION:

Name: _____
Last First MI Other

Address: _____
Street/Box City State Zip Code

Telephone No: (___) _____ Social Security No.: _____

Date of Hire: _____

AP Suspended? **9** Yes **9** No Date: _____ AP Terminated? **9** Yes **9** No Date: _____

CREDENTIALING/LICENSURE INFORMATION

Certificate or License No.: _____
(Attach copy of certificate/license.)

Type of Certification (check those that apply): **9** NAT **9** CNA **9** CMA **9** HHA **9** AD **9** SSD **9** QMRP

9 Other _____

NAT = Nurse Aide Trainee I or II CNA = Certified Nurse Aide CMA = Certified Medication Aide
HHA = Home Health Aide AD = Activities Director SSD = Social Services Designee
QMRP = Qualified Mental Retardation Professional

OR

Type of License (check those that apply):

9 ACHA **9** RN **9** LPN **9** RPT **9** OT **9** LMHT **9** LSW **9** Other _____

ACHA = Adult Care Home Administrator RN = Registered Nurse LPN = Licensed Practical Nurse
RPT = Registered Physical Therapist OT = Occupational Therapist
LMHT = Licensed Mental Health Technician LSW = Licensed Social Worker

THIS SECTION TO BE COMPLETED BY THE REGIONAL MANAGER

Case No.: _____ Code No.: _____ Type: _____

The above-named perpetrator has been found to have:

Regional Manager Signature: _____ Date: _____